Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

MH SURGERY CENTER W HOUSTON
970 CAMPBELL ROAD
HOUSTON TX 77024

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-12-2045-01

MFDR Received:
February 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Per fee guidelines at 253% of mcare."

Amount in Dispute: $2701.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2011	CPT Code 29881 – Ambulatory Surgical Services	$2,701.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets out the general medical provisions for medical fee dispute resolution.

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Tex. Admin. Code §§133.305 and 133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on February 7, 2012 for resolution pursuant to 28 Tex. Admin. Code §133.307. In accordance with 28 Tex. Admin. Code §133.307(c)(1) this dispute was timely filed.

2. 28 Tex. Admin. Code §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care ***not*** [emphasis added] delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Tex. Admin. Code §133.305, and §133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 22, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.